

|  |
| --- |
| Mental Health Support in Schools Team (MHST) Referral Form |

If you have any doubt about this referral or need help to complete it please contact a member of the Team and we would be happy to help you.

Confidentiality

If you are a professional, please discuss this referral with the child/young person and their parent(s) or carer(s). It may be necessary to share information with other professionals so that we can offer the best service to the family.

During the course of their care, some details may be recorded digitally.

For your protection, the use of this data is controlled in accordance with the Data Protection Act, 1998.

|  |
| --- |
| SECTION ONE - CHILD / YOUNG PERSON DETAILS |
| Full Legal Name:  |
| Preferred name/pronoun: | Date of Birth: |
| Gender: | Gender Identity: |
| Current address of child / young person: |
| School / College: | School Attendance: |
| Name of GP: | GP Surgery: |
| GP Surgery Address: | Surgery Telephone and Email Address: |
| Details of the child / young person: (Tick all that apply) |
| ⬜ Living with parents | ⬜ Living with relatives | ⬜ Adopted | ⬜ Looked after child |
| ⬜ Subject to a Child Protection Plan | ⬜ Subject to a Child in Need Plan | ⬜ Subject to an Education, Health and Care Plan | ⬜ Other, please state: |
| Is the child / young person a young carer? ⬜ Yes ⬜ No | Does the CYP consider themselves to be transgender?⬜ Yes ⬜ No |
| Sexual Orientation:⬜ Heterosexual ⬜ Gay ⬜ Lesbian ⬜ Bisexual ⬜ Prefer not to say/Not known |
| Ethnicity:⬜ White British ⬜ Irish ⬜ Gypsy or Irish Traveller ⬜ White and Black Caribbean ⬜ White and Black African ⬜ White and Asian ⬜ Indian ⬜ Pakistani ⬜ Bangladeshi ⬜ Chinese ⬜ Other Asian background ⬜ African ⬜ Caribbean ⬜ Other Black/Caribbean/African Background⬜ Other mixed / multiple ethnic background – please state: |
| First Language: | Is an interpreter required? ⬜ Yes ⬜ NoIf yes, which language: |
| Does the child / young person have a disability or impairment? ⬜ Yes ⬜ NoIf yes, please specify: |
| Does the young person need any extra support when attending appointments? ⬜ Yes ⬜ NoIf yes, please provide details: |

|  |
| --- |
| SECTION TWO - REFERRER DETAILS |
| Name: | Job Title / Profession: |
| Date of Referral: | Telephone: |
| Email Address: |

|  |
| --- |
| SECTION THREE - PARENT / CARER DETAILS  |
| *Priority 1 Contact* |
| Full Name: | Parental Responsibility: ⬜ Yes ⬜ No |
| Relationship to child / young person: | Mobile telephone number: |
| Address: | Email address: |
| *Priority 2 Contact* |
| Full Name: | Parental Responsibility: ⬜ Yes ⬜ No |
| Relationship to child / young person: | Mobile telephone number: |
| Address: | Email address: |
| Is there any history of parental mental health difficulties and/or substance misuse? ⬜ Yes ⬜ No If yes, please specify: |
| Are any adult services currently involved? ⬜ Yes ⬜ NoIf yes, please specify (including length of involvement): |

|  |
| --- |
| SECTION FOUR - CHILDREN'S SERVICES (If not applicable please leave blank) |
| Name of Allocated Social Worker or Family Support Worker: |  |
| Children's Services Team: |  |
| Contact telephone number: |  |
| Contact email address: |  |
| Details and duration of involvement:  |  |

|  |
| --- |
| SECTION FIVE - REFERRAL CONSENT |
|  | If no, please give a reason why: |
| Does the parent / carer consent to the referral? | Yes | No |  |
| Does the child / young person consent to the referral? | Yes | No |  |
| Does the parent / carer and child / young person give consent to forward the referral to appropriate external agencies, e.g. Children’s Services, Education, Voluntary sector, where necessary? | Yes | No |  |

|  |
| --- |
| SECTION SIX - MENTAL HEALTH CONCERNS |
| Primary reason for referral (please tick one): ⬜ Anxiety ⬜ Depression ⬜ Phobias ⬜ OCD ⬜ Panic⬜ PTSD (Single Event Trauma) ⬜ Self-harm |
| Reason for Referral / Presenting Concerns:*Please describe the current nature of mental health difficulties, such as presentation, onset, frequency and duration.*  |
| What impact is this having on the child / young person and those around them?*Consider impact on education / relationships / health / sleep / motivation / engagement / enjoyment of activities.* |
| What services or interventions have been accessed by the child / young person, or their parent / carer in relation to the current concerns?*When were they accessed? For how long? Were they successful? Examples include: social care, early help, school nurse, etc.* |
| Presenting Risk:*Please give details regarding the child / young person's risk to themselves, risk to others, risk from others.* |
| What does the child / young person hope that the MHST can do for them?*Which concerns are impacting them the most? What would they like to be different? How would this look like to them?* |
| Which form(s) of treatment are you requesting/would be appropriate? (please tick all that apply): ⬜ CBT therapy  *Individualised and targeted CBT treatment, working 1:1 with a clinician across a period of time*⬜ Mental health course *Attendance at a short course to work on general areas such as managing worries or mood*⬜ Wellbeing session *A one-off session to discuss general wellbeing and get advice from a clinician. Not appropriate for significant mental health needs.* |
| Any relevant medical history: |
| Are there any concerns relating to substance misuse? ⬜ Yes ⬜ NoIf yes, please provide details: |
| Are there any concerns relating to food / weight / disordered eating? ⬜ Yes ⬜ NoIf yes, please provide details:  |
| Does the child / young person have a neurodevelopmental diagnosis? ⬜ Yes ⬜ NoIf yes, please provide details: |
| Is the child / young person currently taking medication? ⬜ Yes ⬜ NoIf yes, please provide details: |

|  |
| --- |
| Please return completed referrals to MHSTWest@spft.nhs.uk*\*Please be aware that sending by email from iCloud, Gmail, Hotmail, Live, Yahoo or other private email accounts to NHS.net is not secure.* |